Transition Protocol for Individuals Moving from State-Operated Developmental Centers and Community ICF-MR Facilities to the Community Using Money Follows the Person

Money Follows the Person (MFP) Demonstration Project is federal funding used to assist individuals transitioning from institutions and nursing facilities to the community. Individuals are given priority to enroll in the CAP/MR-DD waiver and funding for the first 365 days of community living is provided by MFP funds during the demonstration period. Projected Discharge Date is a date by which the individual is expected to leave the current home and move into the identified new home based on the *Transition Plan*. It is critical that all transition activities be completed as outlined in the *Transition Plan*, prior to the actual move to the new home, to ensure the success of the individual in their new home. Attached to this document is ***A Guide for Transition Planning: Money Follows the Person Project,*** **that provides guidelines regarding the expectations of the Transition Planning process.**

1. The state Money Follows the Person (MFP) specialist/designee will distribute information regarding the MFP project to the:
    - Local Management Entities (LME) Developmental Disability Points of Contact and/or care coordination units
    - Developmental Center transition coordinators (Each Developmental Center transition coordinator will determine their own process for distributing information to other staff of the centers.)
    - community ICF-MR providers

2. LME(s), as lead agents for the Home and Community Based Services (HCBS) waivers for individuals with intellectual and/or developmental disabilities (ID/DD), will inform the provider community of the MFP project, particularly case management and residential provider agencies. Although provider choice may not be limited, LME(s) are encouraged to consider partnering with one or two community providers who have demonstrated expertise in working with individuals with greater challenges to successful community living, such as behavioral issues or special medical needs.

3. Developmental Center staff will call the guardians who have expressed an interest in community living regarding the MFP project. If the guardian is interested in participating in the MFP project, Developmental Center staff will complete the referral form up to the section entitled MFP staff use only. The Developmental Center transition coordinator will send the list of those individuals/guardians who would like to participate in MFP, and the referral form to the respective LME DD Point of Contact and/or care coordinator and the MFP specialist/designee.

    Note: Information provided to individuals/guardians regarding MFP is not limited to this one time initial contact. Developmental center staff will continue to provide ongoing information regarding MFP during annual person centered planning

meetings, when questions are asked by individuals/guardians about community living or as other opportunities arise.

After receiving and completing Section 6 of the MFP Referral Form, the MFP Designee will send the completed MFP Referral Form to the LME DD Point of Contact and the CAP/MR-DD Slot Manager (Best Practice Team, DMH/DD/SAS). The MFP specialist/designee will notify the agency staff listed in Section 2 of the referral form within five business days of the individual's MFP eligibility.

4. Community ICF-MR providers will inform individuals and/or their guardians of the MFP project and the availability of waiver funding for community transitions through a process determined by their agency. The community ICF-MR provider will send the list of those individuals/guardians who would like to participate in MFP and the referral forms to the respective LME DD Point of Contact and/or care coordinator and the MFP specialist/designee.

5. The LME may also identify individuals and/or guardians in community ICF-MR facilities or other qualified institutions who are interested in participating in the project, or the LME(s) may be contacted by an individual and /or guardian directly. In these cases the LME must complete the referral form, notify the institution, and submit the referral form to the MFP specialist/designee.

6. LME staff will contact all individuals and/or guardians that have indicated interest in MFP regarding their participation in the MFP project. The individual/guardian will also be sent an MFP Informed Consent form and a Video Release form to complete and return to the LME. LME staff will fax the completed Informed Consent and Video Release form to the MFP specialist/designee at 919-733-2796 or via USPS.

7. **A**. The individual/guardian will be provided a list of the case management agencies within their catchment area for the selection of a case manager. All individuals transitioning through MFP must have a case manager designated. The LME is responsible for tracking individuals participating in the MFP project, including identifying information and case management and residential provider information. The case manager must notify the LME when they have been selected by the individual/guardian to provide case management.

B. Once a case manager is identified, the LME will notify the CAP/MR-DD Slot Manager (Best Practice Team, DMH/DD/SAS) that a CAP-MR/DD MFP reserved slot is being requested. **Requests for waiver slots must always initiate with the LME**. It is the responsibility of the LME to monitor the status of the transition process to ensure that it is completed in a timely manner in order not to exceed the allowable 60 days of billable case management for transitions. The LME will also notify the Developmental Center or the ICF-MR provider and the MFP specialist/designee that a request has been made for a MFP reserved slot.

The case manager will initiate and conduct all planning meetings to identify transition issues and needs. This requires that the case manager work with the individual/guardian, the Developmental Centers or ICF-MR provider, residential providers and others to develop a transition plan with clear timelines. A copy of the transition plan and timeline must be submitted to the LME by the case manager within two weeks of assuming the individual on their caseload. The LME is responsible for providing an electronic copy of the transition plan and timelines to the MFP specialist/designee at DMA and the CAP/MR-DD Slot Manager (Best Practice Team, DMH/DD/SAS).

8. The case manager will coordinate community visits by the individual/guardian in collaboration with the Developmental Center or community ICF-MR provider.

9. The case manager is responsible for coordinating a projected discharge date and the level of care determination process, outlined in the CAP-MR/DD Manual; including completion of the MR2 to correspond with eh discharge date. The case manager will simultaneously initiate - with the guardian – the process of notifying the local Department of Social Services (DSS) Medicaid eligibility office to determine Medicaid eligibility. The LME must notify the MFP specialist/designee when the MR2 is submitted.

.

NOTE: Projected Discharge Date is a date by which the individual is expected to leave the current home/residence and move into the identified new home based on the Transition Plan. It is critical that all transition activities be completed as outlined in the Transition Plan, prior to the actual move to the new home, to ensure the success of the individual in their new home.

10. The case manager will notify the LME of the projected discharge date. The LME will then notify the state MFP specialist/designee at least four weeks in advance in order to coordinate the completing of a Quality of Life survey required by the Centers for Medicaid/Medicare (CMS).

Once the level of care determination process is complete, the case manager will develop the Person Centered Plan, in collaboration with the individual and guardian, Developmental Center staff, or ICF-MR staff and other identified planning team members. DMH/DD/SAS is required to review and approve for individuals participating in MFP prior to discharge.

The Person Centered Plan (PCP) must include:

- A comprehensive crisis-prevention and intervention plan.
- Explicit information in the crisis plan for addressing potential issues and how they will be addressed for individuals with challenging medical needs,
- A behavior support plan for individuals with challenging behaviors. All individuals with behavioral health needs will be referred to the community NC-START Team for crisis prevention and intervention planning.

11. The case manager will submit the completed PCP 10 business days prior to projected discharge date to Utilization Review (UR) vendor using the urgent fax line (919-461-0679). DMH/DD/SAS will review each plan and make a recommendation to UR vendor for approval/disapproval of the submitted plan.

12. The case manager must notify the LME of the date of the individual's first day in the community. The LME must notify the MFP specialist/designee on the individual's first day in the community.

13. The case manager must notify the LME at any time there are significant issues that could lead to re-institutionalization. The LME will work with the case manager and others on the team to identify solutions and alternatives to re-nstitutionalization. If all efforts to prevent re-instutionalization are not successful and re-institutionalization is necessary, the case manager must notify the LME. Additionally the case manager must notify the LME if the individual has deceased. The LME will in turn notify the MFP specialist/designee and the DMH/DD/SAS waiver staff.

Note: MFP will not be available to the five county area of Piedmont Behavioral Health. This includes the counties of Cabarrus, Davidson, Rowan, Stanley, and Union counties.